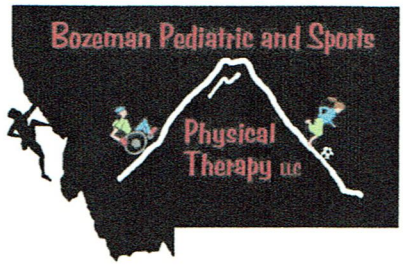

300 N. Willson Ave, Suite 105A

Bozeman, MT 59715

HIPAA Release of information AUTHORIZATION FORM

I, _____hereby authorize Bozeman Pediatric and Sports Physical Therapy, LLC and its affiliates, its employees and agents to verbally communicate and release to:

Check all that apply

() Spouse_____

() Child(ren)_____

() Other_____

my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me: _____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the above address and that it may take up to 30 days to process. However, this authorization may not be revoked if Bozeman Pediatric and Sports Physical Therapy, LLC, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____ **Date:**_____